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	185273	A. BUILDING _____ B. WING _____	C 06/29/2015

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OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY23402) was initiated on 06/22/15 and concluded on 06/29/15. The complaint was substantiated with Immediate Jeopardy identified at 42 CFR 483.20 Resident Assessment (F281 and F282) and 42 CFR at 483.25 Quality of Care (F333) with Substandard Quality of Care at 42 CFR at 483.25 Quality of Care. The Immediate Jeopardy was identified on 06/22/15 and was determined to exist on 06/13/15. On 06/13/15 at approximately 7:30 AM, Licensed Practical Nurse (LPN) #1 administered 125 units of NovoLog 70/30 insulin to Resident #1; however, the insulin was ordered for a different resident (Resident #2). Interview with LPN #1 on 06/22/15 at 3:27 PM, revealed she failed to verify that she was giving the insulin to the correct resident prior to administering the insulin. At approximately 11:30 AM, Resident #1 began to have symptoms of hypoglycemia (low blood sugar level) and was assessed to have a blood glucose level of 20 milligrams per deciliter (mg/dL). The facility submitted an acceptable Allegation of Compliance (AOC) on 06/29/15 alleging the Immediate Jeopardy was removed on 06/17/15. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the IJ was removed on 06/17/15 prior to the SSA initiating the investigation on 06/22/15. Therefore, it was determined to be Past Immediate Jeopardy.	F 000		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 281	Continued From page 1 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, procedures, and training materials it was determined the facility failed to have an effective system to ensure professional standards of quality were maintained for one (1) of three (3) sampled residents (Resident #1). Review of the facility's "Allegation Report and Investigation" form, dated 06/14/15, revealed Resident #1 received insulin that was ordered for another resident. Interview with Licensed Practical Nurse (LPN) #1 revealed she did not verify that she was giving the correct resident the correct medication on 06/13/15 because there was not a divider between the diabetic Medication Administration Records (MAR) for Resident #1 and Resident #2. As a result, LPN #1 administered 125 units of insulin to Resident #1 on 06/13/15 that was ordered for Resident #2. Resident #1 became hypoglycemic (low blood sugar level) and required treatment for hypoglycemia (refer to F282 and F333). Immediate Jeopardy (IJ) was identified on 06/22/15 and was determined to exist on 06/13/15. The facility submitted an acceptable Allegation of Compliance (AOC) on 06/29/15 alleging the Immediate Jeopardy was removed on 06/17/15. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the IJ was removed on 06/17/15 prior to the SSA initiating the investigation. Therefore, it was determined to be Past Immediate Jeopardy.	F 281	Past noncompliance: no plan of correction required.	

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F 281	Continued From page 2 The findings include: Review of the facility's policy titled "Medication Administration- General Guidelines," revision date of 12/18/12, revealed medications were to be administered in accordance with the written order of the attending physician. The policy further revealed residents were to be identified before the medication was administered by the following methods: checking the photograph attached to the medical record, calling the resident by name or if necessary verifying resident identification with other facility personnel. The policy revealed the individual who administered the medication dose should record the administration on the resident's MAR immediately after the medication was given. Review of the American Society of Consultant Pharmacist handout titled "Insulin Injection Tips," dated 2011, revealed a "double check" system should always be used when administering insulin to inspect insulin preparation for correct product selection and correct dosage before administration to the resident. Review of the American Society of Consultant Pharmacist handout titled "Medication Pass Review," dated 2011, revealed the MAR should be reviewed prior to administration of a medication. Continued review of the handout revealed the rights of a medication pass should be used which include: the right resident, the right medication, the right dosage and form, the right time, and the right route. The handout further revealed the resident's identity should be verified by checking the resident's armband, the photograph attached to the chart, or by checking	F 281		

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with other facility personnel.

Record review revealed the facility readmitted Resident #1 on 06/01/15, with diagnoses which included Type 2 Diabetes, Hypertension, and Dementia.

Review of Resident #1's Physician's Orders, dated 06/01/15, revealed an order for NovoLog (insulin) two (2) times per day according to a sliding scale based on blood glucose results.

Review of Resident #1's MAR, dated 06/13/15, at approximately 6:00 AM, revealed Resident #1's blood sugar was 183 milligrams/deciliter (mg/dL) and did not require sliding scale insulin to be administered.

Review of the facility's report titled "Allegation Report and Investigation," dated 06/14/15, revealed on 06/13/15 Resident #1 "received the incorrect insulin." Further review of the investigation revealed LPN #1 contacted the Director of Nursing (DON) on 06/13/15 at approximately 12:00 PM, and reported she had administered Resident #1 125 units of insulin at approximately 7:30 AM that morning which was ordered for Resident #2. The investigation further revealed LPN #1 stated there was no divider in the book that contained the MARs. The investigation report revealed LPN #1 administered the insulin to Resident #1 without assuring she was giving the medication to the correct resident.

Interview on 06/22/15 at 3:27 PM with LPN #1 revealed she was looking through the diabetic MAR at the medications that needed to be administered and had looked at Resident #1's

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blood glucose results and noted the resident did not have sliding scale coverage at that time. LPN #1 stated she continued to look through the MARs and saw the order for the NovoLog 70/30 to be administered twice per day and administered the medication. The LPN stated she did not look at the resident's name on the MAR and there was not a divider separating Resident #1's and Resident #2's MARs and that was why she made the mistake. LPN #1 stated she should have checked the resident's name prior to administration of the medication.

Interviews on 06/22/15 with Registered Nurse (RN) #1 at 1:44 PM, RN #2 at 1:55 PM, RN #3 at 2:05 PM, and LPN #2 at 2:16 PM revealed when administering insulin the nurses would look at the MAR and compare the medication to the MAR at least twice to ensure the right medication was being administered to the right resident. The interviews further revealed if the nursing staff was unfamiliar with a resident there was a picture of each resident in the MAR book or the nurse would ask another staff member to identify the resident.

Interviews on 06/22/15 at 4:15 PM with the Director of Nursing (DON) and Administrator revealed LPN #1 should have followed the five (5) rights of medication administration, should have looked at the name on each page of the MAR and ensured she administered the medication to the correct resident.

*The facility implemented the following actions to remove the Jeopardy:

1. On 06/13/15, Resident #1 was immediately evaluated by two (2) licensed nurses. The

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resident's physician and the resident's responsible party were immediately notified by the facility. The facility provided emergency care immediately to Resident #1 and blood glucose levels continued to rise and within one hour the blood glucose level of Resident #1 was within normal limits at 158. On 06/13/15, the physician ordered the withholding of insulin until the next day, at which time the physician was notified again. At that time, the physician ordered that the insulin be withheld again until the following day (06/15/15). The resident continued on alert monitoring with blood glucose levels checked hourly and the Physician Orders were being followed for Resident #1. The Physician Orders and Comprehensive Care Plan for Resident #1 were reviewed immediately by the Director of Nursing on 06/13/15 to assure compliance for this resident.

2. On 06/13/15, the Director of Nursing instructed the weekend nurse manager to immediately check all other diabetic residents who had been administered diabetic medication by this same nurse for proper administration of diabetic care and any possible side effects. All other residents had received the proper medication with no side effects noted.

3. Insulin is administered as ordered and validated by an additional licensed nurse.

4. The licensed nurse involved was suspended immediately following the event on 06/13/15 and is no longer employed at the facility.

5. The Quality Assurance (QA) Committee (Committee members include the Administrator, Director of Nursing, Medical Director, RN Medical

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Records Director, RN Unit Coordinators, MDS Coordinators, Social Services Director, and Pharmacy Representative) met on 06/15/15 to review the plan outlined herein and results of initial audits and reviews.

6. An audit of the MARs for diabetic residents was completed by the Director of Nursing and RN Unit Manager on 06/14/15. The MARs were compared with the physician's order and then the resident's insulin supply on 06/16/15. The resident names, correct room numbers, and room divider tabs were also validated in the audit completed on 06/14/15.

7. Comprehensive Care Plans for all diabetic residents were reviewed by the MDS Coordinator (LPN) and Medical Records Director (RN) on 06/16/15.

8. On 06/13/15 and 06/14/15, in-services were conducted for Licensed Nurses regarding proper medication administration using the 5 Rights of Medication Administration. Return demonstrations and post testing were completed to validate training on 06/16/15; 2 percent of the licensed nurses were on vacation and cannot return to work until training is complete and 98 percent of the licensed nurses were trained by 06/16/15. Licensed Nurses are not permitted to work until education is completed and confirmed by return demonstration and post test.

9. Two (2) licensed nurses are now required to verify the correct resident, insulin type, and dose prior to administration and according to the 5 Rights of Medication Administration (the right patient, the right drug, the right dose, the right route, and the right time) and according to the

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facility's policies that were reviewed and revised on 06/13/15.

10. The Director of Nursing, the RN Unit Manager, and the RN Medical Records Director completed medication pass observations on all licensed nurses beginning on 06/13/15 through 06/16/15. Observation included administration of insulin and demonstration of the 5 Rights of Medication Administration. Licensed Nurses are not permitted to work until education and return demonstrations are completed. To ensure sustained compliance, validation of physician's orders for insulin type and dose will be performed by an additional licensed nurse prior to administration.

11. Beginning on 06/13/15, the Director of Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators will observe at least one administration of insulin daily (Monday-Friday) and the Director of Nursing, Weekend Manager, or Charge Nurse will complete these observations on week-ends to confirm proper procedure and second nurse's validation.

12. The facility's Pharmacy Representative will conduct Medication Pass observations for licensed nurses on monthly consultations until all nurses have been validated.

13. Beginning on 06/13/15, MAR audits will continue weekly by the Director of Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators (Monday-Friday) and the Director of Nursing, Weekend Manager or Charge Nurse will complete these observations on weekends.

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**The SSA validated the Jeopardy was removed as follows:

1. Record review revealed Resident #1 was assessed by two (2) licensed staff members after the incident occurred on 06/13/15. Further record review revealed Resident #1's responsible party and physician were notified of the resident's low blood sugar result and that treatment for hypoglycemia was ordered and initiated immediately. A review of Resident #1's Diabetic MAR revealed blood glucose levels were obtained every hour until 06/14/15 at 9:00 AM when the order was discontinued by the physician. Review of the progress notes, physician orders, and MAR revealed all physician orders were followed. Interview with LPN #3 on 06/29/15 at 11:02 AM revealed Resident #1 was assessed by two (2) nurses and treatment for hypoglycemia was started immediately. The interview further revealed Resident #1's blood sugar was checked every hour and was stable from one hour after the incident occurred. Continued interview revealed Administrative staff, Resident #1's physician, and Resident #1's responsible party were notified immediately of the incident. LPN #3 revealed the physician orders were followed.

2. Record review revealed on 06/13/15 all diabetic residents that LPN #1 had provided care for were assessed and blood sugar levels were obtained to ensure the residents had been treated appropriately and no issues were identified by facility staff. Interview on 06/29/15 at 11:02 AM with LPN #3 revealed the LPN had assessed and checked blood sugar levels for the other diabetic residents LPN #1 had cared for and

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there were no issues identified with the residents' assessments or with the blood sugar levels.

3. Review of residents' Diabetic MARs revealed all insulin administered was verified by two (2) licensed staff members. Review of diabetic residents' MARs on 06/29/15, revealed all insulin administrations had been verified by two (2) nurses. This was validated by each insulin dose being signed off by two (2) nurses for each administration. Interviews on 06/29/15 with RN #4 at 1:36 PM, RN #5 at 1:43 PM, RN #6 at 1:48 PM, RN #2 at 1:52 PM, RN #8 at 1:56 PM, RN #3 at 2:01 PM, and RN #7 at 2:05 PM revealed the nurses were required to have a nurse witness and verify any insulin administration by observing the preparation of the insulin and the administration of the insulin to the resident. Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON on 06/29/15 at 2:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff members verify all insulin preparations and administrations. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff that insulin preparation and administration had to be verified by two (2) licensed staff members. Observations on 06/22/15 and 06/29/15 of both facility nurses' stations revealed a sign reminding nurses that all insulin administrations were required to be verified by two (2) nurses. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM revealed insulin preparation and administration was verified by two (2) nursing staff members.

4. Review of the "Allegation Report and Investigation" form, final report dated 06/16/15,

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revealed LPN #1 was suspended on 06/13/15 and resigned from the facility on 06/16/15.

5. Review of the sign-in sheet and agenda for the QA meeting on 06/15/15 revealed the following issues were discussed: medication error on 06/13/15, nursing education related to the incident, system change related to the incident, daily and weekly checks of MARs, MAR book tabs, orders and insulin, check-off of skills related to insulin administration, change in new admission check off-sheet and added return demonstration to new hires for insulin administration.

6. Review of audits revealed the facility compared MARs with physician orders and insulin supply between 06/14/15 and 06/16/15. The facility did not identify any issues related to the audits.

7. Review of documentation revealed the MDS staff and the Medical Records RN had completed reviews of all diabetic care plans and no issues were identified. Interviews on 06/29/15 with the MDS staff and the Medical Records RN revealed no issues were identified during the review of the diabetic care plans.

8. Review of facility in-services revealed all nursing staff was educated on 06/13/15 and 06/14/15 on the 5 Rights of Medication Administration. Further review revealed all nursing staff had to perform a return demonstration and post test related to the 5 Rights of Medication Administration. Interview on 06/29/15 at 2:09 PM with the DON revealed all licensed staff had been trained, completed a post test, and completed a return demonstration of the

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5 Rights of Medication Administration. A review of the post test revealed if staff missed an answer on the test, the staff was immediately re-educated and the post test was re-administered until all questions were answered correctly on the test.

9. Review of the facility policy titled "Administration of Insulin Procedure," revision date 06/13/15, revealed insulin preparation and administration will be validated by another licensed nurse. The policy further revealed both nurses would initial on the MAR that the insulin was administered per the physician's orders. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM of insulin administration, revealed insulin was administered per the facility policy.

10. Review of the facility Medication Administration Observation Report revealed medication pass observations were completed by facility staff from 06/13/15 through 06/16/15. Interviews on 06/29/15 with the RN Unit Managers at 1:36 PM and 2:05 PM, the RN Medical Records Director at 1:48 PM, and the DON at 2:09 PM revealed all licensed staff members were observed during medication administration for the 5 Rights of Administration to be followed and for insulin to be administered per the facility policy.

11. Review of the facility's "Daily Insulin Administration" form revealed at least one licensed staff member had been observed daily for following facility policy and using the 5 Rights of Medication Administration during insulin administration since 06/13/15.

12. Review of the facility "Medication

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F 281	Continued From page 12 Administration Observation Report" revealed the facility Pharmacy Representative completed a medication pass observation on 06/16/15. 13. Review of facility audits revealed MAR audits were being completed by facility staff daily.	F 281		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to provide care and services in accordance with the written plan of care for one (1) of three (3) sampled residents (Resident #1). A review of the plan of care for Resident #1 revealed the resident had interventions in place that included finger stick blood sugar checks with sliding scale insulin coverage and medications as ordered by the physician. Review of the facility's "Allegation Report and Investigation" form, dated 06/14/15, revealed Resident #1 received insulin that was not correct according to the resident's plan of care or physician's orders (refer to F281 and F333). On 06/13/15 at approximately 7:30 AM, Licensed Practical Nurse (LPN) #1 administered 125 units of NovoLog 70/30 insulin to Resident #1;	F 282	Past noncompliance: no plan of correction required.	

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however, the insulin was ordered for a different resident (Resident #2). Interview with Licensed Practical Nurse (LPN) #1 on 06/22/15 at 3:27 PM, revealed she failed to verify that she was giving the insulin to the correct resident prior to administering the insulin. At approximately 11:30 AM, Resident #1 began to have symptoms of hypoglycemia (low blood sugar level) and was assessed to have a blood glucose level of 20 milligrams per deciliter (mg/dL).

Immediate Jeopardy (IJ) was identified on 06/22/15 and was determined to exist on 06/13/15. The facility submitted an acceptable Allegation of Compliance (AOC) on 06/29/15 alleging the Immediate Jeopardy was removed on 06/17/15. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the IJ was removed on 06/17/15 prior to the SSA initiating the investigation. Therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility policy titled "Individual and Interdisciplinary Plan of Care," not dated, revealed the policy did not address following resident's plan of care. Interview on 06/29/15 at 1:33 PM with the Director of Nursing (DON) revealed the facility did not have a policy related to staff following the care plan.

Review of the medical record for Resident #1 revealed the facility readmitted the resident on 06/01/15 with diagnoses to include Type 2 Diabetes, Hypertension, and Dementia. Review of the Minimum Data Set (MDS) Assessment with a reference date of 06/13/15 revealed Resident #1 received injectable medication five (5) days

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during the seven (7) days prior to the assessment. Review of the care plan dated 06/01/15 revealed interventions included finger stick blood sugar checks with sliding scale insulin coverage and medications as ordered by the physician.

Review of Resident #1's physician orders, dated 06/04/15, revealed an order for NovoLog (insulin) two times per day according to a sliding scale that was based on finger stick blood sugar check results.

Review of Resident #1's Medication Administration Record (MAR) dated 06/13/15 at approximately 6:00 AM, revealed Resident #1's blood sugar was 183 milligrams/deciliter (mg/dL). According to the physician's order, the resident did not require sliding scale insulin to be administered based on the resident's blood sugar.

Review of the facility report titled "Allegation Report and Investigation," dated 06/14/15, revealed on 06/13/15 Resident #1 "received the incorrect insulin."

Interview on 06/22/15 at 3:27 PM with Licensed Practical Nurse (LPN) #1 revealed she administered insulin to Resident #1 on 06/13/15 at 7:30 AM. LPN #1 stated the diabetic MAR book did not contain a divider between Resident #1 and Resident #2's MARs and the LPN did not look at the name on each page of the MAR. As a result, LPN #1 stated she administered Resident #2's dose of insulin to Resident #1. The interview further revealed medications should always be administered per the physician's orders and per the care plan interventions.

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Interviews on 06/22/15 with Registered Nurse (RN) #1 at 1:44 PM, RN #2 at 1:55 PM, RN #3 at 2:05 PM, and LPN #2 at 2:16 PM revealed medications should always be administered per the physician's orders and per the care plan interventions.

Interview on 06/22/15 at 4:15 PM with the Administrator and DON revealed LPN #1 did not follow Resident #1's plan of care by administering the incorrect insulin to the resident. The Administrative staff revealed medications should be administered per the care plan and physician orders.

*The facility implemented the following actions to remove the Jeopardy:

1. On 06/13/15, Resident #1 was immediately evaluated by two (2) licensed nurses. The resident's physician and the resident's responsible party were immediately notified by the facility. The facility provided emergency care immediately to Resident #1 and blood glucose levels continued to rise and within one hour the blood glucose level of Resident #1 was within normal limits at 158. On 06/13/15, the physician ordered the withholding of insulin until the next day, at which time the physician was notified again. At that time, the physician ordered that the insulin be withheld again until the following day (06/15/15). The resident continued on alert monitoring with blood glucose levels checked hourly and the Physician Orders were being followed for Resident #1. The Physician Orders and Comprehensive Care Plan for Resident #1 were reviewed immediately by the Director of Nursing on 06/13/15 to assure compliance for this

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resident.

2. On 06/13/15, the Director of Nursing instructed the weekend nurse manager to immediately check all other diabetic residents who had been administered diabetic medication by this same nurse for proper administration of diabetic care and any possible side effects. All other residents had received the proper medication with no side effects noted.

3. Insulin is administered as ordered and validated by an additional licensed nurse.

4. The licensed nurse involved was suspended immediately following the event on 06/13/15 and is no longer employed at the facility.

5. The Quality Assurance (QA) Committee (Committee members include the Administrator, Director of Nursing, Medical Director, RN Medical Records Director, RN Unit Coordinators, MDS Coordinators, Social Services Director, and Pharmacy Representative) met on 06/15/15 to review the plan outlined herein and results of initial audits and reviews.

6. An audit of the MARs for diabetic residents was completed by the Director of Nursing and RN Unit Manager on 06/14/15. The MARs were compared with the physician's order and then the resident's insulin supply on 06/16/15. The resident names, correct room numbers, and room divider tabs were also validated in the audit completed on 06/14/15.

7. Comprehensive Care Plans for all diabetic residents were reviewed by the MDS Coordinator (LPN) and Medical Records Director (RN) on

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F 282	Continued From page 17 06/16/15. 8. On 06/13/15 and 06/14/15, in-services were conducted for Licensed Nurses regarding proper medication administration using the 5 Rights of Medication Administration. Return demonstrations and post testing were completed to validate training on 06/16/15; 2 percent of the licensed nurses were on vacation and cannot return to work until training is complete and 98 percent of the licensed nurses were trained by 06/16/15. Licensed Nurses are not permitted to work until education is completed and confirmed by return demonstration and post test. 9. Two (2) licensed nurses are now required to verify the correct resident, insulin type, and dose prior to administration and according to the 5 Rights of Medication Administration (the right patient, the right drug, the right dose, the right route, and the right time) and according to the facility's policies that were reviewed and revised on 06/13/15. 10. The Director of Nursing, the RN Unit Manager, and the RN Medical Records Director completed medication pass observations on all licensed nurses beginning on 06/13/15 through 06/16/15. Observation included administration of insulin and demonstration of the 5 Rights of Medication Administration. Licensed Nurses are not permitted to work until education and return demonstrations are completed. To ensure sustained compliance, validation of physician's orders for insulin type and dose will be performed by an additional licensed nurse prior to administration. 11. Beginning on 06/13/15, the Director of	F 282		

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Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators will observe at least one administration of insulin daily (Monday-Friday) and the Director of Nursing, Weekend Manager, or Charge Nurse will complete these observations on week-ends to confirm proper procedure and second nurse's validation.

12. The facility's Pharmacy Representative will conduct Medication Pass observations for licensed nurses on monthly consultations until all nurses have been validated.

13. Beginning on 06/13/15, MAR audits will continue weekly by the Director of Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators (Monday-Friday) and the Director of Nursing, Weekend Manager or Charge Nurse will complete these observations on weekends.

**The SSA validated the Jeopardy was removed as follows:

1. Record review revealed Resident #1 was assessed by two (2) licensed staff members after the incident occurred on 06/13/15. Further record review revealed Resident #1's responsible party and physician were notified of the resident's low blood sugar result and that treatment for hypoglycemia was ordered and initiated immediately. A review of Resident #1's Diabetic MAR revealed blood glucose levels were obtained every hour until 06/14/15 at 9:00 AM when the order was discontinued by the physician. Review of the progress notes, physician orders, and MAR revealed all physician orders were followed. Interview with LPN #3 on

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F 282	Continued From page 19 06/29/15 at 11:02 AM revealed Resident #1 was assessed by two (2) nurses and treatment for hypoglycemia was started immediately. The interview further revealed Resident #1's blood sugar was checked every hour and was stable from one hour after the incident occurred. Continued interview revealed Administrative staff, Resident #1's physician, and Resident #1's responsible party were notified immediately of the incident. LPN #3 revealed the physician orders were followed. 2. Record review revealed on 06/13/15 all diabetic residents that LPN #1 had provided care for were assessed and blood sugar levels were obtained to ensure the residents had been treated appropriately and no issues were identified by facility staff. Interview on 06/29/15 at 11:02 AM with LPN #3 revealed the LPN had assessed and checked blood sugar levels for the other diabetic residents LPN #1 had cared for and there were no issues identified with the residents' assessments or with the blood sugar levels. 3. Review of residents' Diabetic MARs revealed all insulin administered was verified by two (2) licensed staff members. Review of diabetic residents' MARs on 06/29/15, revealed all insulin administrations had been verified by two (2) nurses. This was validated by each insulin dose being signed off by two (2) nurses for each administration. Interviews on 06/29/15 with RN #4 at 1:36 PM, RN #5 at 1:43 PM, RN #6 at 1:48 PM, RN #2 at 1:52 PM, RN #8 at 1:56 PM, RN #3 at 2:01 PM, and RN #7 at 2:05 PM revealed the nurses were required to have a nurse witness and verify any insulin administration by observing the preparation of the insulin and the administration of the insulin to the resident.	F 282		

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Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON on 06/29/15 at 2:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff members verify all insulin preparations and administrations. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff that insulin preparation and administration had to be verified by two (2) licensed staff members. Observations on 06/22/15 and 06/29/15 of both facility nurses' stations revealed a sign reminding nurses that all insulin administrations were required to be verified by two (2) nurses. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM revealed insulin preparation and administration was verified by two (2) nursing staff members.

4. Review of the "Allegation Report and Investigation" form, final report dated 06/16/15, revealed LPN #1 was suspended on 06/13/15 and resigned from the facility on 06/16/15.

5. Review of the sign-in sheet and agenda for the QA meeting on 06/15/15 revealed the following issues were discussed: medication error on 06/13/15, nursing education related to the incident, system change related to the incident, daily and weekly checks of MARs, MAR book tabs, orders and insulin, check-off of skills related to insulin administration, change in new admission check off-sheet and added return demonstration to new hires for insulin administration.

6. Review of audits revealed the facility compared MARs with physician orders and insulin supply between 06/14/15 and 06/16/15.

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The facility did not identify any issues related to the audits.

7. Review of documentation revealed the MDS staff and the Medical Records RN had completed reviews of all diabetic care plans and no issues were identified. Interviews on 06/29/15 with the MDS staff and the Medical Records RN revealed no issues were identified during the review of the diabetic care plans.

8. Review of facility in-services revealed all nursing staff was educated on 06/13/15 and 06/14/15 on the 5 Rights of Medication Administration. Further review revealed all nursing staff had to perform a return demonstration and post test related to the 5 Rights of Medication Administration. Interview on 06/29/15 at 2:09 PM with the DON revealed all licensed staff had been trained, completed a post test, and completed a return demonstration of the 5 Rights of Medication Administration. A review of the post test revealed if staff missed an answer on the test, the staff was immediately re-educated and the post test was re-administered until all questions were answered correctly on the test.

9. Review of the facility policy titled "Administration of Insulin Procedure," revision date 06/13/15, revealed insulin preparation and administration will be validated by another licensed nurse. The policy further revealed both nurses would initial on the MAR that the insulin was administered per the physician's orders. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM of insulin administration, revealed insulin was administered per the facility policy.

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F 282	Continued From page 22 10. Review of the facility Medication Administration Observation Report revealed medication pass observations were completed by facility staff from 06/13/15 through 06/16/15. Interviews on 06/29/15 with the RN Unit Managers at 1:36 PM and 2:05 PM, the RN Medical Records Director at 1:48 PM, and the DON at 2:09 PM revealed all licensed staff members were observed during medication administration for the 5 Rights of Administration to be followed and for insulin to be administered per the facility policy. 11. Review of the facility's "Daily Insulin Administration" form revealed at least one licensed staff member had been observed daily for following facility policy and using the 5 Rights of Medication Administration during insulin administration since 06/13/15. 12. Review of the facility "Medication Administration Observation Report" revealed the facility Pharmacy Representative completed a medication pass observation on 06/16/15. 13. Review of facility audits revealed MAR audits were being completed by facility staff daily.	F 282		
F 333	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 333		

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F 333	Continued From page 23 Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to have an effective system to ensure one (1) of three (3) sampled residents (Resident #1) was free of significant medication errors. On 06/13/15 at approximately 7:30 AM, Licensed Practical Nurse (LPN) #1 administered 125 units of NovoLog 70/30 insulin to Resident #1; however, the insulin was ordered for a different resident (Resident #2). Interview with Licensed Practical Nurse (LPN) #1 on 06/22/15 at 3:27 PM, revealed she failed to verify that she was giving the insulin to the correct resident prior to administering the insulin. At approximately 11:30 AM, Resident #1 began to have symptoms of hypoglycemia (low blood sugar level) and was assessed to have a blood glucose level of 20 milligrams per deciliter (mg/dL). Immediate Jeopardy (IJ) was identified on 06/22/15 and was determined to exist on 06/13/15. The facility submitted an acceptable Allegation of Compliance (AOC) on 06/29/15 alleging the Immediate Jeopardy was removed on 06/17/15. Based on the State Survey Agency's (SSA) validation of the AOC it was determined the IJ was removed on 06/17/15 prior to the SSA initiating the investigation. Therefore, it was determined to be Past Immediate Jeopardy. The findings include: A review of the facility policy titled "Medication Administration - General Guidelines," revision date 12/18/12, revealed medications were to be administered in accordance with the written order of the attending physician. The policy further revealed residents were to be identified before the medication was administered by the following	F 333	Past noncompliance: no plan of correction required.	

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methods: checking the photograph attached to the medical record, calling the resident by name, or if necessary verifying resident identification with other facility personnel. The policy revealed the individual who administered the medication dose should record the administration on the resident's Medication Administration Record (MAR) immediately after the medication was given.

A review of the American Society of Consultant Pharmacist handout titled "Insulin Injection Tips," dated 2011, revealed a "double check" system should always be used when administering insulin to inspect insulin preparation for correct product selection and correct dosage before administration to the resident.

A review of the American Society of Consultant Pharmacist handout titled "Medication Pass Review," dated 2011, revealed the MAR should be reviewed prior to administration of a medication. Continued review of the handout revealed the rights of a medication pass should be used which include the right resident, the right medication, the right dosage and form, the right time, and the right route. The handout further revealed the resident's identity should be verified by checking the resident's armband, the photograph attached to the chart, or by checking with other facility personnel.

Review of the medical record for Resident #1 revealed the facility readmitted the resident on 06/01/15 with diagnoses to include Type 2 Diabetes, Hypertension, and Dementia. Review of the Minimum Data Set (MDS) Assessment with a reference date of 06/13/15 revealed Resident #1 received injectable medication five (5) days

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during the seven (7) days prior to the assessment. Review of the care plan dated 06/01/15 revealed interventions included finger stick blood sugar checks with sliding scale insulin coverage and medications as ordered by the physician.

Review of Resident #1's physician orders dated 06/01/15, revealed an order for NovoLog (insulin) two times per day according to a sliding scale based on blood glucose results as follows: 201-250 mg/dL = 2 units, 251-300 mg/dL = 4 units, 301-350 mg/dL = 6 units, 351-400 mg/dL= 8 units, and if greater than 400 mg/dL call the physician.

Review of Resident #1's Medication Administration Record (MAR), dated 06/13/15 at approximately 6:00 AM, revealed Resident #1's blood sugar was 183 milligrams/deciliter (mg/dL). According to the physician's order, the resident did not require sliding scale insulin to be administered based on the resident's blood sugar level.

Review of the facility report titled "Allegation Report and Investigation," dated 06/14/15, revealed on 06/13/15 Resident #1 "received the incorrect insulin." Further review of the investigation revealed on 06/13/15 at approximately 12:00 PM, LPN #1 contacted the Director of Nursing (DON) and reported she had administered 125 units of insulin to Resident #1, which was ordered for Resident #2 at approximately 7:30 AM that morning. The investigation further revealed LPN #1 stated there was no divider in the book that contained the MARs and the LPN just flipped the tab and administered the insulin to Resident #1 that was

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ordered for Resident #2. The investigation further revealed at approximately 11:30 AM Resident #1 "was out of it" so the LPN obtained a finger stick blood sugar level of 20 mg/dL. The investigation stated the LPN realized at that time she had given the resident the wrong dose of insulin. The investigation revealed LPN #1 was suspended pending the investigation on 06/13/15 and later resigned on 06/16/15. The investigation further revealed administrative staff, Resident #1's physician, and Resident #1's family were notified of the medication error.

Interview on 06/22/15 at 3:10 PM with Resident #1's Family Member revealed on the day of the incident the resident acted like his/her normal self until approximately lunchtime. The interview further revealed the Family Member passed Resident #1 in the hallway being pushed in a wheelchair by State Registered Nurse Aide (SRNA) #1. The Family Member stated the resident's head was down and he/she appeared to be "very hot and sweaty." Continued interview revealed the SRNA asked the Family Member if this was normal behavior for the resident. The Family Member informed the SRNA that the behavior was not normal, so they took Resident #1 to the nurses' station to be assessed by the nurse. Resident #1's Family Member revealed the nurse checked the resident's blood sugar, the result was very low, and the staff started to treat the resident for the low blood sugar immediately. Continued interview revealed Resident #1 started to "come around" quickly and she was able to get the resident to eat and drink and was happy the resident did not have to go to the hospital. The Family Member further revealed she was informed of the medication error.

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Interview on 06/29/15 at 12:01 PM with SRNA #1 revealed Resident #1 had been resting in bed during the morning but was alert when staff was in and out of the resident's room. The interview further revealed when the staff got Resident #1 out of bed for lunch and into the wheelchair, the SRNA noticed a change in the resident. The SRNA stated she was taking the resident by the nurses' station on the way to the dining room and passed the resident's family member in the hallway. SRNA #1 stated she asked the family member if the resident's behavior was normal. The family member denied to the SRNA the behavior was normal for the resident and the family member and the SRNA took Resident #1 to the nurses' station to be assessed by a nurse.

Interview with LPN #1 on 06/22/15 at 3:27 PM revealed was looking at the diabetic MAR on 06/13/15 during the morning for medications that needed to be administered. She stated she saw Resident #1's blood glucose results and noted the resident did not require insulin according to the resident's sliding scale that was ordered. LPN #1 stated as she continued to look at the MARs, she saw an order for NovoLog 70/30 insulin to be administered twice daily and administered the medication to Resident #1. LPN #1 stated the MARs did not have a divider separating Resident #1 and Resident #2's MAR, and she did not look at the name on the MAR and inadvertently gave the insulin to the wrong resident.

Interview on 06/22/15 at 3:53 PM with Resident #1's Physician revealed LPN #1 called and reported Resident #1's blood sugar was very low. The Physician stated the LPN informed her the resident had only had his/her scheduled insulin that morning. The interview further revealed the

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Physician was very familiar with Resident #1 and was aware the resident did not have an order for a scheduled dose of insulin and only had an order for sliding scale insulin. Continued interview revealed when the LPN informed the Physician what had been administered to Resident #1 the Physician informed the LPN the wrong insulin was administered to the resident and gave orders for treatment of hypoglycemia (low blood sugar level). The Physician revealed she initially gave orders for the resident to be transferred to the hospital; however, since the resident responded so well to treatment and the resident was eating and drinking well she allowed the resident to remain in the facility.

Interview on 06/29/15 at 2:09 PM with the DON revealed LPN #1 informed the DON at approximately 11:30 AM on 06/13/15 that Resident #1 had symptoms of hypoglycemia and the resident's blood sugar was 20 mg/dL. At approximately 12:00 PM on 06/13/15, the DON stated she was notified by LPN #1 of the medication error in which LPN #1 gave insulin to Resident #1 that was ordered for Resident #2. LPN #1 informed the DON the physician was notified and treatment was provided. The DON stated LPN #1 was immediately removed from resident care and suspended and later resigned from the facility on 06/16/15. The interview further revealed the DON immediately initiated an investigation of the incident.

*The facility implemented the following actions to remove the Jeopardy:

1. On 06/13/15, Resident #1 was immediately evaluated by two (2) licensed nurses. The resident's physician and the resident's

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responsible party were immediately notified by the facility. The facility provided emergency care immediately to Resident #1 and blood glucose levels continued to rise and within one hour the blood glucose level of Resident #1 was within normal limits at 158. On 06/13/15, the physician ordered the withholding of insulin until the next day, at which time the physician was notified again. At that time, the physician ordered that the insulin be withheld again until the following day (06/15/15). The resident continued on alert monitoring with blood glucose levels checked hourly and the Physician Orders were being followed for Resident #1. The Physician Orders and Comprehensive Care Plan for Resident #1 were reviewed immediately by the Director of Nursing on 06/13/15 to assure compliance for this resident.

2. On 06/13/15, the Director of Nursing instructed the weekend nurse manager to immediately check all other diabetic residents who had been administered diabetic medication by this same nurse for proper administration of diabetic care and any possible side effects. All other residents had received the proper medication with no side effects noted.

3. Insulin is administered as ordered and validated by an additional licensed nurse.

4. The licensed nurse involved was suspended immediately following the event on 06/13/15 and is no longer employed at the facility.

5. The Quality Assurance (QA) Committee (Committee members include the Administrator, Director of Nursing, Medical Director, RN Medical Records Director, RN Unit Coordinators, MDS

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Coordinators, Social Services Director, and Pharmacy Representative) met on 06/15/15 to review the plan outlined herein and results of initial audits and reviews.

6. An audit of the MARs for diabetic residents was completed by the Director of Nursing and RN Unit Manager on 06/14/15. The MARs were compared with the physician's order and then the resident's insulin supply on 06/16/15. The resident names, correct room numbers, and room divider tabs were also validated in the audit completed on 06/14/15.

7. Comprehensive Care Plans for all diabetic residents were reviewed by the MDS Coordinator (LPN) and Medical Records Director (RN) on 06/16/15.

8. On 06/13/15 and 06/14/15, in-services were conducted for Licensed Nurses regarding proper medication administration using the 5 Rights of Medication Administration. Return demonstrations and post testing were completed to validate training on 06/16/15; 2 percent of the licensed nurses were on vacation and cannot return to work until training is complete and 98 percent of the licensed nurses were trained by 06/16/15. Licensed Nurses are not permitted to work until education is completed and confirmed by return demonstration and post test.

9. Two (2) licensed nurses are now required to verify the correct resident, insulin type, and dose prior to administration and according to the 5 Rights of Medication Administration (the right patient, the right drug, the right dose, the right route, and the right time) and according to the facility's policies that were reviewed and revised

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10. The Director of Nursing, the RN Unit Manager, and the RN Medical Records Director completed medication pass observations on all licensed nurses beginning on 06/13/15 through 06/16/15. Observation included administration of insulin and demonstration of the 5 Rights of Medication Administration. Licensed Nurses are not permitted to work until education and return demonstrations are completed. To ensure sustained compliance, validation of physician's orders for insulin type and dose will be performed by an additional licensed nurse prior to administration.

11. Beginning on 06/13/15, the Director of Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators will observe at least one administration of insulin daily (Monday-Friday) and the Director of Nursing, Weekend Manager, or Charge Nurse will complete these observations on week-ends to confirm proper procedure and second nurse's validation.

12. The facility's Pharmacy Representative will conduct Medication Pass observations for licensed nurses on monthly consultations until all nurses have been validated.

13. Beginning on 06/13/15, MAR audits will continue weekly by the Director of Nursing, the RN Unit Manager, the RN Medical Records Director, and the MDS Coordinators (Monday-Friday) and the Director of Nursing, Weekend Manager or Charge Nurse will complete these observations on weekends.

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F 333	Continued From page 32 **The SSA validated the Jeopardy was removed as follows: 1. Record review revealed Resident #1 was assessed by two (2) licensed staff members after the incident occurred on 06/13/15. Further record review revealed Resident #1's responsible party and physician were notified of the resident's low blood sugar result and that treatment for hypoglycemia was ordered and initiated immediately. A review of Resident #1's Diabetic MAR revealed blood glucose levels were obtained every hour until 06/14/15 at 9:00 AM when the order was discontinued by the physician. Review of the progress notes, physician orders, and MAR revealed all physician orders were followed. Interview with LPN #3 on 06/29/15 at 11:02 AM revealed Resident #1 was assessed by two (2) nurses and treatment for hypoglycemia was started immediately. The interview further revealed Resident #1's blood sugar was checked every hour and was stable from one hour after the incident occurred. Continued interview revealed Administrative staff, Resident #1's physician, and Resident #1's responsible party were notified immediately of the incident. LPN #3 revealed the physician orders were followed. 2. Record review revealed on 06/13/15 all diabetic residents that LPN #1 had provided care for were assessed and blood sugar levels were obtained to ensure the residents had been treated appropriately and no issues were identified by facility staff. Interview on 06/29/15 at 11:02 AM with LPN #3 revealed the LPN had assessed and checked blood sugar levels for the other diabetic residents LPN #1 had cared for and there were no issues identified with the residents'	F 333		

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assessments or with the blood sugar levels.

3. Review of residents' Diabetic MARs revealed all insulin administered was verified by two (2) licensed staff members. Review of diabetic residents' MARs on 06/29/15, revealed all insulin administrations had been verified by two (2) nurses. This was validated by each insulin dose being signed off by two (2) nurses for each administration. Interviews on 06/29/15 with RN #4 at 1:36 PM, RN #5 at 1:43 PM, RN #6 at 1:48 PM, RN #2 at 1:52 PM, RN #8 at 1:56 PM, RN #3 at 2:01 PM, and RN #7 at 2:05 PM revealed the nurses were required to have a nurse witness and verify any insulin administration by observing the preparation of the insulin and the administration of the insulin to the resident. Interview on 06/29/15 at 11:02 AM with LPN #3 and the DON on 06/29/15 at 2:09 PM revealed the licensed staff was immediately informed to have two (2) licensed staff members verify all insulin preparations and administrations. The interview further revealed signs were posted on the nursing units on 06/13/15 reminding all licensed staff that insulin preparation and administration had to be verified by two (2) licensed staff members. Observations on 06/22/15 and 06/29/15 of both facility nurses' stations revealed a sign reminding nurses that all insulin administrations were required to be verified by two (2) nurses. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM revealed insulin preparation and administration was verified by two (2) nursing staff members.

4. Review of the "Allegation Report and Investigation" form, final report dated 06/16/15, revealed LPN #1 was suspended on 06/13/15

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and resigned from the facility on 06/16/15.

5. Review of the sign-in sheet and agenda for the QA meeting on 06/15/15 revealed the following issues were discussed: medication error on 06/13/15, nursing education related to the incident, system change related to the incident, daily and weekly checks of MARs, MAR book tabs, orders and insulin, check-off of skills related to insulin administration, change in new admission check off-sheet and added return demonstration to new hires for insulin administration.

6. Review of audits revealed the facility compared MARs with physician orders and insulin supply between 06/14/15 and 06/16/15. The facility did not identify any issues related to the audits.

7. Review of documentation revealed the MDS staff and the Medical Records RN had completed reviews of all diabetic care plans and no issues were identified. Interviews on 06/29/15 with the MDS staff and the Medical Records RN revealed no issues were identified during the review of the diabetic care plans.

8. Review of facility in-services revealed all nursing staff was educated on 06/13/15 and 06/14/15 on the 5 Rights of Medication Administration. Further review revealed all nursing staff had to perform a return demonstration and post test related to the 5 Rights of Medication Administration. Interview on 06/29/15 at 2:09 PM with the DON revealed all licensed staff had been trained, completed a post test, and completed a return demonstration of the 5 Rights of Medication Administration. A review

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of the post test revealed if staff missed an answer on the test, the staff was immediately re-educated and the post test was re-administered until all questions were answered correctly on the test.

9. Review of the facility policy titled "Administration of Insulin Procedure," revision date 06/13/15, revealed insulin preparation and administration will be validated by another licensed nurse. The policy further revealed both nurses would initial on the MAR that the insulin was administered per the physician's orders. Observations on 06/22/15 at 5:00 PM and 5:10 PM, and on 06/29/15 at 11:26 AM and 11:35 AM of insulin administration, revealed insulin was administered per the facility policy.

10. Review of the facility Medication Administration Observation Report revealed medication pass observations were completed by facility staff from 06/13/15 through 06/16/15. Interviews on 06/29/15 with the RN Unit Managers at 1:36 PM and 2:05 PM, the RN Medical Records Director at 1:48 PM, and the DON at 2:09 PM revealed all licensed staff members were observed during medication administration for the 5 Rights of Administration to be followed and for insulin to be administered per the facility policy.

11. Review of the facility's "Daily Insulin Administration" form revealed at least one licensed staff member had been observed daily for following facility policy and using the 5 Rights of Medication Administration during insulin administration since 06/13/15.

12. Review of the facility "Medication Administration Observation Report" revealed the

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F 333	Continued From page 36 facility Pharmacy Representative completed a medication pass observation on 06/16/15. 13. Review of facility audits revealed MAR audits were being completed by facility staff daily.	F 333		